Metro Human Resources

2005 Benefit Election Form (Employee)

For Coverage Effective January 1, 2005

Fastnet #:

SSN:

Employee Name (First, M, Last)

Instructions: Read the back of this page before completing this form. If you have **NO CHANGES** to your current benefit elections and you do not want to enroll in an FSA, **DO NOT** complete this form**. Print in blue or black ink.**

Benefit	2005 Election / Option (check one per benefit)	2005 Coverage Level (check one per benefit)
Medical Plan	☐ BCBS PPO ☐ Cigna HMO (PCP#_____) ☐ HealthSpring HMO (PCP#_____)	☐ Single ☐ Family ☐ Split* (Spouse's SSN:_____)
Dental Plan	☐ Preferred ☐ Premier	☐ Single ☐ Family
Vision Plan	☐ Enroll me ☐ Discontinue my coverage	☐ Single ☐ Family ☐ Split* (Spouse's SSN:_____)
Supplemental Life [1]	☐ Enroll me in the amount of $_____ (**multiples of $10,000, up to 3 x salary, $200,000 maximum**) **Note**: The maximum you may elect is $_____ based upon your annual salary as of August 26, 2004. If you are electing supplemental life insurance for the first time, or if you are increasing your coverage by $20,000 or more, you must complete the Evidence of Insurability Form in your *Enrollment Guide.* ☐ Discontinue my coverage	
Dependent Life	☐ Enroll my dependents **Note**: If you are electing dependent life for the first time, you must complete the Evidence of Insurability Form in your *Enrollment Guide.* You must be enrolled in supplemental life before enrolling your dependents. ☐ Discontinue my coverage	
Short-Term Disability	☐ Enroll me ☐ Discontinue my coverage	
Long-Term Disability	☐ Enroll me Note**:** If you are electing long term disability for the first time, you must complete the Medical History Statement in your *Enrollment Guide.* ☐ Discontinue my coverage	
Flexible Spending Accounts (FSAs)	Health Care FSA amount: $_____ (minimum of $240, maximum of $5,000)	Dependent Care FSA amount: $_____ (minimum of $240, maximum of $5,000)

* Split coverage is available to Metro employees who: 1) are married to a Metro employee or pensioner 2) are enrolled in the same Metro medical and/or vision plan as their spouse, and 3) enroll dependent children in the plan(s). (All three requirements must be met.) The employee or pensioner enrolling in Split coverage carries the dependents. You must list dependent(s) under Split coverage below.

Dependent Information - If you are changing your medical or dental elections, **list all dependents** you want to cover, even if your dependent information is correct on your Personal Benefit Statement. All eligible dependents are covered under the Vision Plan if you elect Family vision coverage.

Name	SSN	Male/Female	Birth Date	PCP #	Desired Coverage
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental
					☐ Medical ☐ Dental

Acknowledgement — I attest and affirm that each person named above is related to me by law and is my true legal dependent. I authorize the adjustment of my annual taxable salary based on my elections above. I understand that my elections will be in effect from January 1, 2005, through December 31, 2005, unless I experience an eligible change in status.

Employee Signature: _____ Date: _____

Current Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Work Phone Number: _____

[1] Supplemental Life maximum amount will not appear if you are an employee of Metro Nashville Public Schools. Airport Authority, Register of Deeds or Circuit Court Clerk.